

# The prevalence of sexual assault in a genitourinary medicine clinic: service implications

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## Abstract

**Objectives**—To determine the prevalence of sexual assault amongst patients attending a department of genitourinary medicine and to investigate the circumstances of the assault.

**Setting and subjects**—The Department of Genitourinary Medicine (GUM), St. Mary's Hospital, London. All patients attending the walk-in GUM Clinic over a fixed time period were invited to take part in the study.

**Methods**—Patients were asked to complete an anonymous questionnaire designed by the investigators.

**Results**—351 (209 women, 142 male) usable questionnaires were returned of 370 distributed. Seventy five persons (21.4%) reported sexual assault: 59 (28.2%) women and 16 (11.3%) men. The incident occurred more than three months before presentation in the majority of persons studied (93%). Twenty one per cent reported the assault to the police, and 34% attended for medical screening. For those who did attend for medical screening, 61% informed their doctor of the assault. The main reason for non-reporting to police and medical staff was "a wish to forget". Counselling was sought by 24% after the sexual assault.

**Conclusions**—A past history of sexual assault is common amongst GUM clinic attenders, more often disclosed amongst women. Reporting both to police and medical services is low. Clinicians need to be sensitive to the fact that a significant proportion of patients attending GUM services may have been sexually assaulted either in the present or the past and the impact that this may have on health care usage. GUM clinics may be ideally placed to provide medical and psychological support to these individuals.

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## Introduction

Sexual assault represents a major crime against the person from which recovery is often traumatic and long-term. The medical and psychosocial consequences of sexual assault are wide ranging and may include

physical injury, sexually transmitted diseases including HIV, risk of pregnancy, gynaecological trauma, medically explained and unexplained somatic symptoms, chronic illness, emotional disturbance, post-traumatic stress disorder, suicide, and substance abuse.<sup>1-3</sup> Increasing attention is being drawn to an association between a history of sexual victimisation and overall increased medical system utilisation. Such studies suggest that a greater awareness amongst health-care professionals of the medical and psychosocial variables associated with sexual victimisation may aid early identification of previously undisclosed rape trauma, and help reduce long-term health care costs.<sup>4</sup> There are, however, few data available specifically on the prevalence of sexual assault among medical attenders.

The incidence of sexual assault is increasing.<sup>5</sup> The number of rape offences recorded in 1992 by the police in England and Wales was 4100, which is over three times the number recorded in 1982. It is suggested that these figures are attributable in part to an increase in reporting to police<sup>6</sup>; however, studies in the United Kingdom have estimated that only 20-25% of cases of sexual assault of women are reported to the police.<sup>7</sup> This figure may be even lower in cases involving marital rape and where the assailant is known to the victim.<sup>8</sup> In addition, studies have suggested that men who have been sexually assaulted are even less likely to report to police. This may be partly attributable to there having been no legal recognition of males as victims of rape in the United Kingdom, although presently legal recognition is being sought and because of stigmatisation.<sup>9-10</sup>

Precise figures of the prevalence of sexual assault are thus difficult to assess. A survey questionnaire distributed to 2,000 women in London found that 17% reported completed rape (60% of these were marital rape) and a further 20% had been victims of attempted rape.<sup>8</sup> There is little research on the prevalence of sexual assault in men aside from a few reports on prison populations.<sup>11</sup> However, a recent study of homosexually active men in the United Kingdom found that 27.6% had been sexually assaulted at some point in their lives.<sup>12</sup>

Men and women may attend genitourinary clinics after sexual assault for screening to exclude sexually transmitted diseases, to gain access to emergency contraception, and because of the confidentiality that GUM clinics provide. The risk of acquiring a sexually transmitted disease as result of rape

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is difficult to assess because of the low reporting rates, varying definitions of sexually transmitted diseases and pre-existing infections in the individual. Two studies from London report rates of 29% and 30% respectively of STDs, excluding bacterial vaginosis and candida.<sup>13,14</sup> Much of this may represent infection unrelated to the sexual assault, but individuals still require treatment. Individuals or the support agencies who refer often raise the issue of HIV testing. The risk of acquiring HIV by sexual assault is not known, although there is one documented case in the UK.<sup>15</sup> A study from Seattle showed no seroconversion in 123 female patients of whom 42% were reviewed at follow-up 8 weeks later.<sup>16</sup> Despite these low rates many individuals request HIV testing. Furthermore, amongst male victims the verbal threat of HIV infection is often made by assailants.<sup>10</sup>

A number of individuals may present to a genitourinary clinic as the first place of disclosure of their sexual assault. It may also be possible that owing to difficulties in disclosing sexual assault a number of patients may request screening for sexually transmitted diseases without informing their doctor of their reason for attending. The need for GUM clinics to be prepared to deal with both the short- and long-term consequences of sexual assault including medical and psychological support has been recognised in one study.<sup>13</sup>

There has been no study to date examining the prevalence of sexual assault in a GUM population. The aim of this study was to determine the prevalence of sexual assault in men and women in a GUM population, to investigate characteristics of the sexual assault including reporting and reasons for non-reporting to police and medical staff, and to examine the use of medical and counselling services and establish preference for provider of care.

## Methods

During August 1993 questionnaires were randomly given to patients attending the walk-in clinic for sexually transmitted diseases at St. Mary's Hospital, London. Patients were informed that the questionnaire related to sexual assault and verbal consent was obtained from all participants. The question-

naire was completed anonymously and was not related to the case notes. Patients were excluded if English was not their first language. This was the only exclusion criterion.

The questionnaire was designed by the investigators to provide information on four aspects: the demographic characteristics of respondents enabling comparisons to be made between assault and non-assault patients, the circumstance of any assault, the use of police, medical and counselling services and potential improvements that could be made to services offered within a GUM department. The questionnaire also contained a section where respondents were invited to make additional comments.

The characteristics of the assault and non-assault groups were compared using chi square analyses.

## Results

Three hundred and seventy questionnaires were administered over the study period of which 351 were returned with usable data. Sexual assault was reported by 75 (21.4%) of the respondents in the past; of these 59 were female and 16 were male. This represents 28.2% of the female sample and 11.3% of the male sample. Tables 1 and 2 show the demographic characteristics of the assault and non-assault groups separated by gender. There were no statistically significant differences with respect to age, ethnicity, sexual orientation, employment status, higher education, and civil status within male and female assault and non-assault groups. A trend in the male sample was noted for white/Caucasian males to be over represented in the assault group ( $p = 0.098$ ).

### Characteristics of the sexual assault

Male and females reporting sexual assault were compared on demographic characteristics (see tables 1 and 2). Females were younger (69.5% between 19–30) than male respondents (56.3% over 31 years) ( $p = 0.01$ ), and there was greater ethnic diversity in the female sexual assault group when compared with the male sexual assault group ( $p = 0.02$ ).

Table 3 shows the method of sexual assault (categories were defined by the question-

Table 1 Demographic characteristics of the sexual assault/non-assault groups by gender

	Male $n = 142$			Female $n = 209$			Sexual assault by gender
	Assault $n = 16(11.3)$	Non-assault $n = 126(88.7)$	$p$ value	Assault $n = 59(28.2)$	Non-assault $n = 150(71.8)$	$p$ value	
Age(years) <18	1 (6.3)	1 (0.8)		4 (6.8)	9 (6.0)		
19–30	6 (37.5)	67 (53.2)		41 (69.5)	100 (66.7)		
31–40	4 (25)	39 (31)		12 (20.3)	31 (20.7)		
41–50	4 (25)	13 (10.3)		2 (3.4)	8 (5.3)		
>50	1 (6.3)	6 (4.8)	NS	0	2 (1.3)	NS	$\chi^2 = 13.2$ df = 4 $p = 0.01$
Heterosexual	6 (37.6)	71 (58.2)		49 (90.7)	132 (93.6)		
Homosexual	10 (62.5)	49 (40.2)		2 (3.7)	3 (2.1)		
Bisexual	0	2 (1.6)	NS	3 (5.6)	6 (4.3)	NS	NS
Caucasian	15 (100)	94 (75.8)		35 (61.4)	88 (59.1)		
Caribbean	0	20 (16.1)	$p =$	13 (22.8)	48 (32.2)		$\chi^2 = 8.3$ df = 2 $p = 0.02$
African	0	10 (8.1)	0.098	9 (15.8)	13 (8.7)	NS	

Table 2 Demographic characteristics continued

	Male n = 142			Female n = 209			Sexual assault by gender
	Assault n = 16(11.3)	Non-assault n = 126(88.7)	p value	Assault n = 59(28.2)	Non-assault n = 150(71.8)	p value	
Employed	8 (50)	85 (68.5)	NS	29 (51.8)	96 (66.2)	NS	NS
Not employed	8 (50)	39 (31.4)		27 (48.2)	49 (33.8)		
College	13 (86.7)	82 (82.8)	NS	37 (77.1)	99 (79.2)	NS	NS
No college	2 (13.3)	17 (17.2)		11 (22.9)	26 (20.8)		
Single	13 (81.3)	95 (76)	NS	44 (74.6)	116 (77.3)	NS	NS
Divorced/separated	2 (12.5)	12 (9.6)		6 (10.2)	15 (10)		
Married/cohabiting	1 (6.3)	18 (14.4)		9 (15.3)	19 (12.7)		

naire). Twenty (34%) females and 3 (20%) males reported more than one method of assault. Of females 77% reported forced vaginal penetration, and 19% reported forced anal penetration. Of the males 50% reported forced anal penetration, and 31% reported oral sex. The category "other" (female 12.3%; male 12.5%) was self-defined by the respondent and included perceived modes of sexual assault such as attempted rape, being masturbated on, being "exposed" to, homophobic attack, and touching.

Of males 40% and of females 26.3% indicated that they had received physical injury in association with the sexual assault. The majority of respondents (male = 87.5%, female = 85.5%) were assaulted by one assailant, but two men and eight women reported an assault involving multiple assailants. For the majority (95%) of respondents, the sexual assault had taken place more than three months earlier. Fifty per cent of males compared to 24.1% of females reported their assailant to be "a stranger" ( $p = 0.05$ ). Knowledge of the assailant is represented in table 4 (respondents indicated more than one category).

#### Reporting and reasons for non-reporting of sexual assault to police and medical services

No significant differences were found between male and female respondents in reporting of the sexual assault to police and medical services. Of males 12.5% and of females 24.1% reported the sexual assault to the police. For both men and women (58.6%) the category of "a wish to forget" was most often responded

to as the reason for not reporting the sexual assault to the police, followed by "fear of not being believed" (32.8%), fear of reactions of others (27.6%), knowledge of assailant (24.1%), and a fear of appearing in court (24.1%). Of males 25% and of females 37.9% attended for medical examination as a result of the sexual assault. Reasons for not attending for medical examination were reported accordingly: "a wish to forget" (52.2%), "no need for medical examination" (45.7%), "fear of not being believed" (10.9%), and "fear of medical examination" (4.3%). All the males ( $n = 4$ ) who attended for medical examination informed their doctor of the sexual assault, but only 12 of 22 females who attended for medical examination informed their doctor of the assault. The main reasons for not informing the doctor of the assault were "a wish to forget" (55.6%), "not important for doctor to know" (33.3%), and "fear of not being believed" (22.2%).

#### Use of medical services

Of those who attended for medical examination, usable data on reasons for seeking medical advice were only obtained for 3 men and 20 women. The reasons for attendance were: treatment for injuries (2 men, 8 women), advice about sexually transmitted diseases (0 men, 15 women), contraception (9 women), HIV testing (1 man, 7 women), access to counselling (2 men, 5 women). One man and 13 women reported that they had been offered all of these services.

#### Use of counselling services

Five (35.7%) men and 13 (24.1%) women attended for counselling. Counselling was obtained from (in rank order of use): 1. Rape crisis lines; 2. Victim support; 3. Other local counselling services; 4. Private counselling; 5. Police; and 6. GUM. clinic. Respondents were asked whether "if a counselling service for people who have been sexually assaulted was offered at this clinic, would this be useful to you?" Seven (50%) men and 21 (39.6%) women responded "yes", two (14.3%) men and 14 (26.4%) women responded "no", and five (35.7%) men and 18 (34%) women responded "maybe".

#### Preference for place of medical examination following sexual assault

Respondents were asked their preference for where a medical examination following sexual

Table 3 Methods of sexual assault

Method	Male n(%)	Female n(%)
Vaginal penetration	NA	44 (77.2)
Anal penetration	8 (50)	11 (19.3)
Oral sex	5 (31.3)	5 (8.8)
Digital penetration	4 (25)	14 (24.6)
Insertion of instruments	0	1 (1.8)
Other	2 (12.5)	7 (12.3)

Table 4 Profile of relationship of assailant to victim

Assailant	Male n(%)	Female n(%)
Stranger	8 (50)	14 (24.1)
Acquaintance	5 (31.3)	21 (36.2)
Family member	4 (25)	13 (22.4)
Partner/ex-partner	1 (6.3)	14 (24.1)

assault should be carried out. Forty per cent of respondents indicated "no preference" for site of medical examination; 34% indicated preference for attending a GUM clinic; 21% (all female) indicated preference for GP clinics and Family Planning Clinics; and 6% indicated a preference for attending a police medical examination suite.

#### *Gender preference of medical examiner and counsellor*

Female respondents indicated a strong preference to be medically examined by a female doctor as compared with male respondents who were less likely to express a preference ( $p = 0.0001$ ). Female respondents were also more likely to indicate a preference for a female counsellor as compared with male respondents who were less likely to express a preference ( $p = 0.0002$ ).

#### *Comments made by respondents*

Sixteen respondents from the sexual assault group wrote comments outside the scope of the categorical responses. The main themes derived from these were: 1. Emotional expression about the assault, such as anger at assailants, lack of recognition of male rape; 2. Confusion about the assault, such as too young to know what to do, "if it is my boyfriend and I didn't want sex, is it sexual assault?"; 3. Comments about the questionnaire design, for example, only assumes one incidence of sexual assault, should include child sexual abuse experiences.

### **Discussion**

This study confirms that a substantial number of GUM clinic attenders have experienced sexual assault at some point in their lives. Of women 28.2% and of men 11.3% in the survey sample reported a history of sexual assault. The result for female sexual assault is similar to rates of sexual assault found in general population survey studies in the United States,<sup>17 18</sup> and further support the estimate that at least one in four women will have been sexually assaulted at some time in their lives. Unfortunately, there are as yet little comparison data of rates of sexual assault in men but this study adds support to previous studies documenting that sexual assault occurs, and more importantly, that it is not an uncommon occurrence.

Men and women reporting a history of sexual assault were generally representative of the GUM clinic attenders at St. Mary's. The pattern of sexual assault in the women in this study resembles that reported by the Metropolitan Police Forensic Science Laboratory in that female victims were predominantly white, under age 30 years, with vaginal intercourse being the predominant mode of assault.<sup>5</sup> Male victims in this study were older than female victims and were more likely to report their sexual orientation as homosexual. However, no differences between men with regard to sexual orientation were found between assault and non-assault

groups in this study, which contrast with a previous report finding a predominance of homosexual or bisexual men amongst victims.<sup>9</sup> Caution should be exercised in making any generalisations from these demographic data as this clinic population may not be representative of other GUM clinic populations or the population as a whole. In addition, no conclusions can be drawn from the male sexual assault sample since numbers are small.

Various methods of sexual assault were reported by the respondents. These may not all constitute a legal definition of rape (that is, at the time of the data collection: penile-vaginal penetration) but it was decided by the researchers that inclusion purely by legal definition would have resulted in a much lower rate of response. Clearly in any provision of medical and psychological services to victims, it is the individual's perception of what constitutes non-consensual sexual activity which must be considered. Nevertheless, the main modes of sexual assault in this survey were vaginal penetration (77%) for women and anal penetration (50%) for men. Nineteen per cent of females also reported anal penetration. A limitation of this section of the study was created by not defining the receptive/insertive dimensions of anal penetration in men, and oral sex in men and women. Such data are obviously relevant for any future studies looking at risks of acquiring STDs and HIV following sexual assault.

The data on the relationship of the assailant to the victim demonstrate that for the majority of females and half the males, the assailant was known in some capacity to the victim prior to the sexual assault. Such findings have been reported in other studies, and clearly challenges the myth that sexual assault is usually perpetrated by a stranger. In this study males were twice as likely to report their assailant to be a stranger as compared with female victims. Physical injury as a result of the sexual assault was reported by both male and female victims, although this was not quantified nor whether medical treatment was required.

Data on reporting to police revealed low rates; approximately 1 in 10 men and 2 in 10 women reported the sexual assault to the police. That men are less likely to report to the police following sexual violence than women has been suggested in a few studies.<sup>9 10</sup> These data raise some serious questions about the reasons why men and women do not report. It might be assumed that factors such as lack of belief in the judicial system to convict and acquaintance with the assailant prior to the assault would be major contributors to non-reporting. Respondents in this study were given defined response categories to attempt to answer the question about reasons for non-reporting, and the most responded to category was "a wish to forget" for both men and women. This category was also most often responded to for the reasons for not attending for medical examination and for not informing the doctor of the sexual assault. This finding may be in part a result of the survey

method, and more reliable data may have been obtained by allowing respondents to define their own reasons for non-reporting. Nevertheless, it raises cause for concern as a reason for non-reporting being perhaps less amenable to change than, for example, improving police, judicial, and medical services which might encourage people to come forward after sexual assault.

Data on the use of medical and counselling services were limited owing to the small numbers of respondents indicating that they had attended for medical examination. Nevertheless, medical concerns included treatment for injuries, sexually transmitted diseases, HIV testing, contraception, and access to counselling. This raises the issue of which medical service is best able to provide for these varied concerns and whether they can all be provided at one site. Overall no clear preference was indicated by the respondents for the place of medical examination following sexual assault, although GUM clinics were slightly favoured above general practitioners and family planning clinics, but this could represent bias in the sample in that all the respondents were attending a GUM clinic. A greater proportion of men and women indicated that they would make use of a counselling service for people who have been sexually assaulted if it was provided in the GUM clinic than actually made use of counselling from a variety of non-medical services following the sexual assault. This may indicate the need for a more immediately accessible counselling service to be made available to victims of sexual assault. This finding also suggests that men and women indicate that they would use a counselling service many months or years after the incident of sexual assault, and may suggest unresolved rape trauma. Although this study was not specifically focusing on the latter aspect of sexual assault, there was some indication from the comments made by respondents that this might indeed be the case.

Respondents were also asked about their gender preference for a medical examiner and counsellor, and females were more likely to express a strong preference to be seen by another female for both medical examination and counselling as compared with males who were less likely to express a preference.

A methodological limitation of this study concerned the question relating to the timing of when the sexual assault had taken place. As the majority (95%) of respondents reported that the sexual assault occurred more than three months ago, recall of information on what occurred at the time and what services were used may not have been very accurate. In addition, it is possible that some sexual assaults reported in the study may have occurred in childhood. An improvement in

design would be achieved by asking approximate dates of the sexual assault episode and would also allow documentation of more than one life-time sexual assault incident.

A further limitation of this study is that the accuracy of information received might have been improved by conducting the questionnaire in an interview format for those who disclosed sexual assault. It may, however, be the case that the anonymity of the survey provided a more accurate rate of sexual assault in the population. This is supported by the finding that the rate of sexual assault in women found in this clinic population closely resembles that found in general population surveys.

In conclusion, we have found a high rate of sexual assault in men and women attending a GUM clinic and confirmed that reporting of sexual assault to both police and medical services is low. Improved management of sexual assault in GUM clinics should include increasing the accessibility of a range of services to meet both the short and long-term physical and psychosocial consequences. Increased public awareness of this provision may help victims to disclose sexual assault and decrease associated morbidity.

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